Since 1879, Tanager Place, a private nonprofit organization, has served at-risk children and families in Iowa. Tanager Place provides a full continuum of care, including inpatient treatment, an outpatient mental health clinic, community-based support services, prevention services, camp program, Pediatric Integrated Health Care services, and research. Tanager Place serves 4,000 children and their families annually.

Tanager Place has a long history of successful development and implementation of innovative programs. Some of these efforts include:

- Helped create and was the first Psychiatric Medical Institution for Children in Iowa
- Built a compressive expressive arts program
- Developed a specialized program for children with intellectual disability and mental health diagnosis
- Created Iowa's only camp program for children with hemophilia
- Established one of only two camps in Iowa for children with diabetes
- Developed a specialized training program to train clinicians to work more effectively with children with type 1 diabetes
- Created an innovative collaboration to develop neighborhood-specific, school-based prevention programming

Recognizing the importance of research-driven practice, Tanager Place created the Tanager Place Research Center in 2012. The center is a collaboration between Tanager Place and five academic institutions. Current research projects include Cornell College research to identify the biological correlations of eating disorders in order to develop more effective diagnosis and treatment for children. The University of Iowa is engaged in a study of filial therapy, conducted in collaboration with

play therapists at the Tanager Place Mental Health Clinic, integrating proven family-based interventions to enhance child behavior, build strong parent-child relationships, and shorten the length of treatment.

Tanager Place's 134-year history of success is based on mission-driven innovation and advocacy for what we believe is in the best interests of children.

As we continue to define, develop and implement policy supporting integrated health care, I have concerns for the effect on the vulnerable children Tanager Place serves.

While there is substantial dialog regarding the need to integrate physical and behavioral health care, there is nearly always a tendency for the behavioral health care portion of the continuum to be less than fully considered.

Health care is so massive that this is completely understandable.

Even given a focused discussion on behavioral health care, the needs of children with mental health issues are often an afterthought.

Children with both a behavioral diagnosis and a chronic physical condition are an even smaller subset that is often not considered at all in system design – despite the fact that this small population can result in significant health costs.

Children with type 1 diabetes are one example of a population that will benefit from an effective integrated health care policy.

In 1986, Tanager Place partnered with the medical community in Cedar Rapids to develop and implement the Tanager Place Diabetes Camp. The camp has been an annual success since then.

As a result of this longstanding involvement, we recognize that children with type 1 diabetes express increased psychological morbidity. This phenomenon has been well researched. Thirty percent (30%) of children develop a mental health disorder within the first three months of initial diagnosis of diabetes. Some studies have indicated that over a 10-year period psychiatric disorder in youth with diabetes was found to be approximately 47%.

We know that depression and behavior problems are associated with an increased risk of multiple diabetes-related hospitalizations.

We also know that there is an additional risk of increased mental health morbidity with other members of the immediate family. Mothers specifically are at increased risk of experiencing clinical depression.

Higher mental health morbidity and higher family conflict are closely related to poor disease management.

Recognizing the need to improve the coordination of care for children with diabetes, Tanager Place formed the Diabetes Service Committee in 2009. This committee is comprised of representatives of the medical community and support organizations. With input from the committee, the Tanager Place Mental Health Clinic developed training to increase the competency of clinicians serving children with type 1 diabetes. Successful implementation of the training supported the development of a team of five Tanager Place clinicians who offer outpatient therapy and play therapy specialized for children with type 1 diabetes. This service is currently at full capacity with a waiting list.

I would like to share with you today a case example of a child we treated in this outpatient program. This case clearly illustrates the need for coordinated care with this group of children.

The patient was an early adolescent boy referred to treatment over concerns about managing his diabetes. The patient would follow recommendations for checking blood sugar and taking insulin but refused to participate in other aspects of care related to his diabetes. He had been diagnosed with type 1 diabetes for years; however, he was afraid of needles and refused anything having to do with needles. Parents or other adults administered all insulin shots. Once the patient began using an insulin pump for delivery, his parents changed every infusion set for him (the needle inserted under the skin that delivers the insulin). While he followed most recommendations, he had started to try to avoid changing this infusion set by not telling his parents he was low on insulin; leaving the site in for longer than indicated, which caused redness and soreness; or trying to only change the reservoir in the pump. This avoidance was causing increasing conflict between the boy and his parents. His physician was concerned about spikes in high blood sugars and his increasing A1C reading.

Tanager Place began individual therapy on a regular basis. Our therapist diagnosed the patient with anxiety disorder and provided treatment to both patient and parents. The therapist utilized cognitive behavioral interventions to help change the patient's irrational thought process specifically related to needles. The patient reported feeling less anxious and worried and was more willing to allow his parents to change his infusion set. His diabetes team noticed a decrease in high blood sugars corresponding to the time of infusion set change. However, the boy was still unwilling to change the set on his own.

The therapist worked with the patient and parents to create an incentive program so the patient could gradually take over small, incremental steps in the process of changing the infusion set. The parents created small rewards and a large award for him so that he received positive reinforcement on a regular basis and had something to look forward to upon completing the entire infusion set change.

Therapist and patient created a system of individualized coping skills to use during specific times of changing the infusion set. Gradually, he began doing each step and eventually changed the entire set on his own. Utilizing a timer, the patient created additional goals to be able to change his infusion set more quickly. Eventually he internalized the reinforcement, becoming more self-confident and in control of his own diabetes, and being proud of his accomplishments.

Over the course of treatment, the patient's blood sugars stabilized and were often in target range. His A1C decreased and stayed in the range specified by his physician. His specific anxiety about needles significantly decreased. Overall, the family functioning greatly improved.

This is a typical case and clearly shows the need for integrating and coordinating care. Without the behavioral intervention of Tanager Place, the outcomes for this adolescent would have been far different, with potentially serious consequences for his future physical health and decidedly increased health care costs.

Children with type 1 diabetes are just one example of the numerous groups of children experiencing chronic physical health conditions coupled with a higher risk for co-occurring mental health issues.

As we consider a major revision in health care delivery, I would urge you to consider the needs of these vulnerable groups. Considering the needs of children with type 1 diabetes is like looking at the amplified needs of every child's health care. Clearly, not every child needs access to this highly specialized care, but every child should have access to a system that can recognize the need and deliver the care.

Paying attention to the small, highly vulnerable groups will have a positive impact for the entire population.

Policy design and policy implementation are two entirely different tasks. For this effort to be truly successful, we must build in frequent system assessments and opportunities for redesign and recalibration.

This point cannot be overemphasized. I have been a professional in the field for 40 years and have seen multiple system redesigns. One of the primary weaknesses of these efforts was the failure to critically assess the impact of the policy and make subsequent adjustments.

Redesigning health care policy on this scale means that mistakes or miscalculations can have disastrous impact on highly fragile populations such as the children Tanager Place serves.

We need to do everything in our power to minimize the chance of that occurring.